Physicians' Newsletter

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Patient Medical Travel Assistance

Often, patients are required to travel outside their local communities to obtain specialized health care. To help alleviate some of the costs related to medical travel, the Ministry of Health supports two travel assistance programs. Please acquaint yourself with these programs so that you can help your patients who are obliged to travel away from home for medical care.

Travel Assistance Program

The Travel Assistance Program (TAP) is a partnership between the Ministry of Health and a number of private transportation partners who agree to offer discounted fares to eligible British Columbia residents who present a completed and approved travel assistance form. Travel to obtain GP services does not qualify under this program unless there is no family physician practicing or providing care in the patient's home community. Referral must be to a medical specialist or specialty service in a hospital or clinic.

All patients enrolled with MSP are eligible for this program unless their medical travel is covered by a third-party insurance plan, such as employer plans, active ICBC, Workers' Compensation or Department of Veterans' Affairs, Canadian Armed Forces, or other federal government programs.

A patient escort is also eligible provided (1) the patient requires an escort for medical reasons; or (2) the patient is 18 years of age and under. An escort is not eligible when driving a vehicle on behalf of a patient who does not fall under (1) or (2), or when travelling alone to or from picking up or dropping off a patient.

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Ministry of Health Services

Patient Medical Travel Assistance continued from page 1

Current travel partners participating in TAP include BC Ferries, Central Mountain Air, Ltd., Harbour Air, Hawkair, Helijet, North Pacific Seaplanes, Pacific Coastal Airlines, Angel Flight, VIA Rail and Pacific Coach Lines.

Need TAP forms?

TAP forms are individually numbered and cannot be faxed or copied. Physicians can obtain TAP forms by calling HIBC Provider Services at 1-866- 456-6950 (toll free) or 604-456-6950 (for the Greater Vancouver area), or by faxing your request to: HIBC Provider Services at (250) 405-3592.
Be sure to include your name, mailing address, and MSP Practitioner Number with your faxed request.

Health Connections

Health Connections is a regional travel assistance program that offers subsidized transportation options to help defray costs for rural residents who must travel to obtain non-emergency medical care outside their home communities. Health Authorities, through funding from the Ministry of Health, have implemented Health Connections programs to meet the unique needs of selected communities in their regions.

The Interior Health Authority has partnered with regional districts and BC Transit to improve public transportation options and to increase access to non-emergency medical appointments through local bus services.

The Northern Health Authority provides bus services for patients needing to travel for out-of-town medical appointments in northern BC and to travel to Vancouver, Kamloops and Grande Prairie, Alberta. Northern Health Connections is operated under contract to Northern Health by Diversified Transportation Ltd. (DTL) of British Columbia, a division of Pacific Western Transportation.

The Vancouver Island Health Authority supports a non-profit volunteer organization called "Wheels for Wellness" which provides transportation for Vancouver Island patients to access specialist medical care in Victoria and Vancouver.

The Vancouver Coastal Health Authority assists residents living in the Central Coastal area (Bella Bella and Bella Coola) with travel to Vancouver for specialist medical care.

For more information about the Travel Assistance Program and links to Health Connections, go to:
http://www.healthservices.gov.bc.ca/msp/mtapp/index.html
or call: (250) 952-1587

Outstanding Claims Review

The Medical Services Branch is aware that some physicians have recently experienced delays in receiving payment of claims due to a higher than usual volume of unpaid manually processed claims.

The Medical Services Plan receives and processes over 6.5 million claims monthly. The time required to process a claim varies depending on the date of submission, complexity of the item, and accuracy of the billing. Approximately 98.3 percent of submitted claims are processed within 30 days, 96 percent on the first payment date following claims submission, and the remainder require manual adjudication and are processed at a later date.

The Medical Services Branch continuously monitors the follow of claims processing and is aware the volume of unpaid manually processed claims is higher than usual. This could be due to a number of reasons, including the recent high volume of new/changed fee items and their increasing complexity.

In order to address this priority issue, the Medical Services Branch has provided two schedules of billing seminars in the previous 12 months to assist physicians' staff and is currently working with Maximus BC, our service delivery provider, to develop strategies to address the backlog and improve the flow of manually processed claims.

Mental Health Management Fee Item Changes

Effective July 1, 2008 the following changes have been made to the Mental Health Management Fees:

1. The description of fee item G14045 is amended as indicated:
   G14045-GP Mental Health Management Fee age 50–59

2. A new fee item is added for age 2-49:
   G14044-GP Mental Health Management Fee age 2–49

The following notes apply to fee items G14044 to G14048:

These fees are payable for GP Mental Health Management required beyond the four (4) MSP counselling fees (age-appropriate 00120 fees billable under the MSP payment schedule) for patients with a chronic mental health condition for whom a Mental Health Plan has been created and billed.

Notes:

i. Payable a maximum of 4 times per calendar year per patient;
ii. Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician;
iii. Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician;
iv. Not payable unless the age-appropriate 00120 series has been fully utilized;
v. Minimum time required is 20 minutes;
vi. Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14049 (GP Mental Health Telephone/Email Management Fee);
vii. G14016 (Community Patient Conferencing Fee) payable on same day or same patient if all criteria met;
viii. G14015 (Facility Patient Conferencing Fee) not payable on same day as facility patients not eligible;
ix. CDM fees (G14050, G14051, G14052) payable if all criteria met.

Location Codes – Y4 Refusals

Please ensure you put the correct location code on your claims or they may refuse Y4 (service location code missing or invalid). In general, the key point to remember when choosing a location code is that it should reflect the actual place where the service is performed.

The location codes are:

C	Residential Care/Assisted Living Residence
D	Diagnostic Facility
E	Hospital-Emergency Room (unscheduled patient)
I	Hospital –Inpatient
P	Hospital Outpatient
R	Patient's Private Home
Z	Other (e.g., accident site or ambulance)
M	Mental Health Centre
T	Practitioner's Office- In Publicly Administered Facility
G	Hospital-Day Care (Surgery)
F	Private Medical/Surgical Facility
A	Practitioner's Office-In Community

Broadcast Messages – Reminder

Broadcast Messages are one of our primary communication vehicles for sharing important information with the physicians of British Columbia. Information regarding new or amended fee items and other billing issues is conveyed via broadcast messages. Please ensure this information is shared with staff responsible for submitting claims to Health Insurance BC.

Expanded Coverage of Biologics for Crohn's Disease

Effective September 9, 2008, Pharmaceutical Services Division:

- modified the Special Authority criteria for biologics for Crohn's disease to include moderate Crohn's disease;
- introduced a quick, one-page patient assessment form based on the Harvey-Bradshaw Index;
- expanded coverage to include an additional biologic, adalimumab (Humira®), under the modified criteria; and
- offered a single request form for initial/renewal coverage to be completed by a gastroenterologist.

Criteria Change:
The previous criteria provided for treatment of severe, active Crohn's disease and fistulizing Crohn's disease. The modified criteria provide for treatment of moderate to severe, active Crohn's disease and fistulizing Crohn's disease as defined on the Special Authority forms.

Duration of coverage:

- Initial coverage adalimumab or infliximab during induction period.
- Renewal coverage for maintenance treatment with either drug, if effective—up to one year.

Forms Changes:
To reflect the changes, we updated the Special Authority forms as follows:

- HLTH 5368—This single form can now be used to request initial / renewal coverage of adalimumab / infliximab for either moderate to severe, active Crohn's or fistulizing Crohn's.
- HLTH 5374—This worksheet provides the scoring for the patient's Harvey Bradshaw Index (the resulting score is entered on the request form HLTH 5368 above).
- HLTH 5347 & 5348—These forms are no longer needed.

Visit the Special Authority section of our website for the forms and full criteria for coverage: www.health.gov.bc.ca/pharme/sa/criteria/restricted/restrictedtable.html.

Expanded Coverage of Biologics for Rheumatoid Arthritis

Effective June 30, 2008, abatacept (Orencia®) and rituximab (Rituxan®) became eligible for PharmaCare coverage through our Special Authority Program for the treatment of severely active rheumatoid arthritis, in combination with methotrexate, for patients who:

- have not responded to a trial of etanercept plus either adalimumab or infliximab, or
- have contraindications to anti-TNF agents.

All requests must be submitted by a rheumatologist. All criteria and the following forms are available in the Special Authority section of our website at www.health.gov.bc.ca/pharme/.

- HLTH 5345—Adalimumab/Etanercept/Infliximab & Abatacept/Rituximab—Initial Coverage or Switching
- HLTH 5373—Abatacept/Rituximab—Coverage Renewal

Please note that Special Authority coverage cannot be provided retroactively and that actual coverage is subject to the patient's usual PharmaCare plan rules, including any annual deductible requirement.

Expanded Coverage of Drug Treatments for Chronic Hepatitis B

Effective March 27, 2008, Pharmaceutical Services Division began offering:

- extended PharmaCare Special Authority coverage for lamivudine (Heptovir®) and interferon alfa-2b (Intron A®); and
- new Special Authority coverage for adefovir (Hepsera®—DIN 2247823) and entecavir (Baraclude®—DIN 2282224).

All medications are Limited Coverage Drugs with approval subject to specific criteria. Please note that:

- all physicians can prescribe these medications and request Special Authority coverage for patients; and
- only faxed or mailed requests can be accepted as lab results are required.

Coverage cannot be provided retroactively and is subject to the patient's usual PharmaCare plan rules, including any deductible requirement.

The full criteria for adefovir and entecavir is listed on the two-page Special Authority form (HLTH 5372). This form replaces the existing request forms for lamivudine and interferon alfa. It includes sections for initial and renewal coverage and is available on the PharmaCare website at: www.health.gov.bc.ca/pharmc/sa/criteria/formsindex.html.

The BC Provincial Academic Detailing (PAD) service – your Rx for evidence-informed prescribing

The BC Provincial Academic Detailing (PAD) service is a new program that will provide a balanced source of evidence-based drug information to B.C. physicians.

Academic detailing is a form of continuing medical education in which health professionals, usually pharmacists, visit physicians one-on-one to discuss drug therapy. Research shows that academic detailing helps to ensure that the most appropriate and effective medications are prescribed. Current, accurate and objective information about new and existing drug therapies can assist physicians with prescribing decisions and improve health outcomes for patients.

The new PAD service is modeled after an innovative program that was started in North and West Vancouver. A clinical pharmacist met with family practice physicians one on one or in small groups to discuss a variety of drug therapy topics such as antihypertensive drugs, heart failure medications, and hormone replacement therapies. Now, academic detailing services are available in five Canadian provinces, as well as in Australia, New Zealand, England, the Netherlands and the United States.

Funding for the PAD service is provided to UBC and regional health authorities by the Ministry of Health Services' Pharmaceutical Services Division. A total of 10 full-time pharmacists will be hired to visit up to 2,000 physicians throughout the province. The pharmacists will receive specialized training in academic detailing and on each therapeutic topic.

Drug therapy topics are recommended by a broad-based advisory committee which includes representatives from the BC College of Family Physicians, the University of BC's Faculty of Medicine, the British Columbia Medical Association and the College of Pharmacists of BC. PAD educational materials are written by clinical experts and peer reviewed by at least two physicians. A physician in each region provides a regional commentary.

The first topic is Human Papilloma Virus (HPV) vaccine. This timely topic will explain the evidence behind the school program and discuss special cases that fall outside the school program. The second topic will be anticoagulation in atrial fibrillation.

The Fraser Health Authority is the first to implement the PAD service. Pharmacists Michael Loure (michael.loure@fraserhealth.ca) and Vivian Yih (vivian.yih@fraserhealth.ca) will be contacting physicians in this region to arrange a visit.

Physicians in other health authorities should contact Erin Guiltenane (604-660-1978) for more information about the service.

Designated Statutory Holidays 2009

Jan	01	Thur	New Year's Day
Apr	10	Fri	Good Friday
Apr	13	Mon	Easter Monday
May	18	Mon	Victoria Day
Jul	01	Wed	Canada Day
Aug	03	Mon	BC Day
Sep	07	Mon	Labour Day
Oct	12	Mon	Thanksgiving Day
Nov	11	Wed	Remembrance Day
Dec	25	Fri	Christmas Day
Dec	28	Mon	In lieu of Boxing Day

Close-Off Dates

Jan	06	July	06
Jan	21	July	22
Feb	04	Aug	05
Feb	18	Aug	20
Mar	04	Sep	03
Mar	20	Sep	21
Apr	02	Oct	05
Apr	21	Oct	21
May	06	Nov	03
May	20	Nov	19
Jun	04	Dec	04
Jun	19	Dec	18

Reminder – Facility Patient Conference Fee and Community Patient Conference Fee

Fee item 14015 – Facility Patient Conference Fee

- the conference must be requested by the facility (to review ongoing management of the patient in that facility or to determine if the patient can safely return to the community or transition to a supportive care or long-term facility)
- it must be performed in the facility (face-to-face meetings are expected, only under exceptional circumstances will care conference by teleconference be payable – chart entry required)
- required interdisciplinary team meeting of at least 2 health professions (may also include family members)
- location code provided on the claim should reflect the location of the conference (usually location code I or C)
- maximum payable per patient is 90 minutes (6 services) per year and 60 minutes (4 services) per day
- start and end time must be stated
- visit is payable if consecutive but not payable if done concurrently
- per 15 minutes or greater portion thereof

Fee item 14016 – Community Patient Conference Fee

- location code provided on the claim should reflect the location of the conference (usually location code A or R)
- maximum payable per patient is 90 minutes (6 services) per year and 60 minutes (4 services) per day
- start and end time must be stated
- visit is payable if consecutive but not payable if done concurrently
- per 15 minutes or greater portion thereof

Prolonged Counselling

Billings for prolonged counselling continue to be a significant issue for the Billing Integrity Program (BIP) and are the subject of a number of audits that are currently underway and others that are planned in the near future. BIP specifically monitors billings for prolonged counselling on an ongoing basis and schedules audits of physicians whose practitioner profile statistics fall outside the billing patterns of their peers. Prolonged counselling visit fee items are listed in the General Practice section of the Payment Schedule and also in a number of specialty sections.

In order to bill prolonged counselling in accordance with the Payment Schedule, there are a number of criteria, all of which must be met. The fact that a visit exceeds the twenty minute minimum time period in itself does not qualify for billings under the prolonged counselling fee items. Preamble clause B4.c sets out a number of criteria that are also required in order that prolonged counselling fee items can be properly billed:

1) Counselling is defined as a discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress. Not only must the condition be recognized as difficult by the medical profession, but the medical practitioner's intervention must of necessity be over and above the advice which would normally be appropriate for that condition; and
2) Counselling cannot be delegated and must last at least 20 minutes; and
3) Counselling cannot be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether the visit is prolonged or not. (For example, the counselling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counselling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns. Also, the counselling codes are generally not applicable to the explanation of the results of diagnostic tests; and

4) Counselling cannot be claimed for educational advice including group educational sessions (e.g., asthma, cardiac rehabilitation and diabetic education); it would be appropriate to apply for sessional payments for group educational sessions; and
5) Unless the patient is having significant difficulty coping, the counselling listings would normally not be applicable to subsequent visits in the treatment of disease; and
6) Counselling by telephone is not a benefit under MSP.

Examples of appropriate claims under the counselling listings include psychiatric care, counselling that may be necessary to treat a significant grief reaction, and conjoint therapy and/or family therapy for significant behavioural problems. MSP payment for counselling under the counselling listings is limited to four sessions per year per patient unless otherwise specified. Subsequent counselling is payable under the other visit listings.

Group Counselling

The group counselling fee items found in the General Practice and various specialty sections of the Payment Schedule apply only when two or more patients are provided counselling in a group session lasting 60 minutes or more. The word "patients" is very important because the group counselling fee items are not applicable when there is a discussion with the patient in the presence of a caregiver, spouse or relative when the patient is the only person requiring medical care. Unless the caregiver, spouse or relative are themselves patients in a true doctor-patient relationship and have a specific medical condition requiring counselling (e.g., couples marriage counselling), the individual prolonged counselling fee item or a visit fee item is applicable. No billing should be submitted under the PHN of the caregiver, spouse or relative in such circumstances.

The group counselling fee items are not billable for each person in the group. Claims should be submitted under the name of only one of the beneficiaries, with the names of the other patients attending the session listed in the note record. Times should be included with billings for group counselling fee items.

Audit Reports

Dr. A. – General Practice

A GP came to the attention of the Billing Integrity Program as a result of the family constellation project, a project designed to review physicians who disproportionately bill for multiple members of the same family on the same date of service, and a routine review of practitioner billing profiles which revealed that the practitioner's referral costs and utilization of prolonged counselling visit fee items were considerably higher than the group average and could not be readily explained. A peer medical inspector found missing and inadequate records for a small number of cases and large numbers of incorrectly billed prolonged counselling visits which should have been billed as regular office visits or complete examinations. The higher than normal referral costs (consultant specialists and diagnostic tests) were found to be justifiable and medically required.

As a result of a negotiated settlement, the physician agreed to repay the Commission $85,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule.

Dr. B. – General Practice

A GP came to the attention of the Billing Integrity Program as a result of a routine review of practitioner billing profiles. A review of the practitioner's billing profile revealed that the practitioner's total referred services and costs per patient were considerably higher than the group average, and could not be explained by subsequent case-mix analysis which adjusts costs for patient age, gender and morbidity. A peer medical inspector found records that were somewhat disorganized (information in many charts was not in chronological order), incorrect billing for prolonged counselling visits, a number of specialist referrals that appeared to have been made on the basis of the patient's request and not medically required based on the patient's medical condition, and a tendency to use diagnostic coding for generalized symptomatology rather than the diagnostic coding appropriate to the patient's clinical condition.

As a result of a negotiated settlement, the physician agreed to repay the Commission $10,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule.

Dr. C – Anaesthesiologist

An anaesthesiologist came to the attention of the Billing Integrity Program as a result of a referral from MSP as the result of an unusual billing pattern under fee items 01207 (Surcharge – non-operative, weekend and statutory holidays) and 01217 (Anaesthesia surcharge – non-operative, weekend and statutory holidays) related to surgical procedures that were performed in a private surgicentre and appeared to be elective in nature. The anaesthesiologist had failed to instruct billing staff that the procedures were electively booked and did not qualify for the weekend surcharges. The anaesthesiologist agreed to pay back $17,400 including interest.

The Payment Schedule states, "Anesthetic services are eligible for continuing care surcharges when an out-of-office hours call-out charge is applicable or when specially called for an emergency." The Payment Schedule goes on to state that surcharges also apply "under the following conditions:
i) as an emergency;
ii) to provide "top-ups" under fee code 01103 or for obstetrical epidural anesthesia;
iii) to provide subsequent resuscitative care under fee code 01088."

Explanatory Note (b) in the "Out-Of-Office Hours Premiums" section states, "Call-out charges apply only when the physician is specially called to render emergency or non-elective services and only when the physician must travel from one location to another to attend the patient(s)."
Note (vii) following the anaesthesia surcharge fee items also states, "Anesthetic surcharges are applicable to services associated with elective surgery which, because of intervening emergency surgery, extends into or commences within the designated times."

Dr. D. – General Practice

A GP came to the attention of the Billing Integrity Program as a result of routine service verification audits that identified potential billing issues relating to consultations and services that may have been of a cosmetic nature and therefore not insured benefits under the Medical Services Plan. A peer medical inspector found missing consultation reports for a small number of cases and a number of incorrectly billed services which should not have been billed to MSP as they were not considered insured benefits.

As a result of a negotiated settlement, the physician agreed to repay the Commission $35,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule.

Dr. E. – General Practice

A GP initially came to the attention of the Billing Integrity Program as the result of a patient complaint and a review of the practitioner billing profile suggested that billings for complete physical examinations (CPX) and fecal occult blood testing (FOBT) were high. A medical inspector found missing and inadequate records for a number of cases and identified a number of incorrectly billed prolonged counselling visits and complete physical examinations which should have been billed as regular office visits. Furthermore, there were billings for FOBT where there was no documentation indicating that the test had been performed or what the test results were.

As a result of a negotiated settlement, the physician agreed to repay the Commission $30,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule.

Dr. F - General Practice

A general practitioner came to the attention of the Billing Integrity Program regarding the improper billing of the long-term care institution visit fee items. The physician had gradually increased the utilization of fee item 00115 (long-term care institution visit – one patient, when specially called during the day hours) to the virtual exclusion of the other fee items relating to long-term care institution visits.

As a result of a negotiated settlement, the physician agreed to repay the Medical Services Commission $50,000 and to abide by the correct submission of claims in accordance with the requirements of the MSC Payment Schedule.

Dr. G - Internal Medicine

An internal medicine specialist came to the attention of the Billing Integrity Program as the result of the routine review of practitioner billing profiles. The internist's practitioner profile showed high costs and services per patient as well as an unusually high utilization of full consultations with a concomitant low utilization of limited/repeat consultations and continuing care visits. A service verification audit revealed a significant number of billing irregularities and an on-site audit was undertaken. A peer medical inspector found missing and inadequate records for a number of cases and identified a significant number of services billed as full consultations which should have been billed as repeat/limited consultations or continuing care subsequent office visits.

As a result of a negotiated settlement, the internist agreed to repay the Commission $65,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule. The internist agreed to bill consultations to MSP only when the attending physician specifically requests a consultation for a difficult medical problem. In cases where continuing care is required for the same general problem for which the initial referral was made, the internist agreed to bill the appropriate subsequent office, hospital or home visit fee item in accordance with the Payment Schedule. This applies even if six months or more have elapsed since the initial consultation was rendered. The internist agreed that the six month time period noted in the Payment Schedule applies only to those situations where the care of the patient has been entirely returned to the attending physician and a new consultation has been specifically requested by the attending physician on the basis that there is a medical requirement for a new consultation.

Audit Billing Tips

Locum Tenens

Preamble clauses A.2 and A.3 of the MSP Payment Schedule summarize the requirements of the Medicare Protection Act that only the practitioner number of the physician who personally provided the insured service should be used on the claim submitted to MSP for payment. The payment of the service can be assigned to another person or corporate body, if the payment is not to be directed to the physician who rendered the service.

It is common that the doctor, who has retained a locum tenens during an absence from the practice, wishes to receive the payment for the services provided by the locum tenens. In these circumstances, an "Assignment of Payment" form should be completed and submitted to HIBC such that all the claims for services rendered by the locum tenens are billed under the practitioner number of the locum tenens and the payee for these claims is the number of the physician (or the corporation) who (which) owns the practice. This form can be obtained from HIBC or on the internet at https://www.health.gov.bc.ca/exforms/msp/prac/2870fil.pdf . More information about payment assignment can be found in the MSP Resource Manual for Physicians at http://www.health.gov.bc.ca/msp/infoprac/physbilling/s5-procedures.pdf .

It is also advised that there be a formal written agreement between the parties covering all the financial terms associated with the services of the locum tenens. Such an agreement falls outside the purview of the Ministry of Health but the Ministry often becomes aware of problems that arise in the absence of such agreements. It is strongly recommended that such agreements include provisions for not only fees for single services but also those fees that encompass long periods of time where some of the service is provided by the physician who owns the practice and some of the service is provided by the locum tenens. Examples of such fees where disputes might arise include annual incentive fees, pre- and post operative care, annual complex care management fees, chronic disease management fees, et cetera.

One might wonder why this information is included as an "audit billing tip". There have been instances where physicians have not followed the requirements of the Medicare Protection Act regarding the submission of claims under the practitioner number of the doctor who actually renders the service and this has distorted the billing statistics for the doctor who owns the practice. This can lead to unnecessary attention from the Billing Integrity Program, something most doctors would prefer to avoid.

Enhancements to Locum Prgrams

The Ministry of Health Services and the British Columbia Medical Association are pleased to announce changes to strengthen the Rural GP Locum Program (RGPLP) and the Rural Specialist Locum Program (RSLP). These changes are being made based upon the recommendation of the Joint Standing Committee on Rural Issues.

Background:
The RGPLP is a provincial program that supports and enables rural general practitioners (GPs) to have periods of leave from their practices for Continuing Medical Education, vacation and health needs. GP locums receive a travel honorarium and a guaranteed daily rate when providing coverage in Rural Subsidiary Agreement (RSA) communities with seven or fewer GPs.

The RSLP provides subsidized periods of leave for eligible specialists in designated communities for purposes such as Continuing Medical Education, vacation and to assist in the provision of continuous specialist coverage as designated by the health authority.

Enhancements:
Effective October 1, 2008, changes to B.C.'s Rural General Practitioner and Rural Specialist Locum Programs will provide further support for physicians practicing in eligible rural communities across the province. The breakdown of changes for both programs is:

RURAL GP LOCUM PROGRAM	
CURRENT PROGRAM	**CHANGES OCTOBER 1, 2008**
Minimum daily rate for all rural communities: $750	Minimum daily rate scaled by community isolation category: A = $900 / day B = $850 / day C = $800 / day D = $750 / day
No premiums for enhanced skills	Additional premiums paid to locums for enhanced skills required by rural hospitals: $100 / day for General Surgery and/or Anesthesia $50 / day for Emergency Room and/or Obstetrics
Maximum locum days for host physicians for all eligible rural communities: 28 days	Maximum locum days for host physicians scaled by community isolation category: A = 43 days B = 38 days C = 33 days D = 28 days
RURAL SPECIALIST LOCUM PROGRAM	
CURRENT PROGRAM	**CHANGES OCTOBER 1, 2008**
Daily rate paid to specialist locums: $1000 / day	Daily rate paid to specialist locums: $1200 / day
Maximum locum days for host specialist physicians: 28 days	Maximum locum days for host specialist physicians: 35 days

For information on the changes to the RGPLP and RSLP, as well as information on how to become a locum, please visit the Ministry of Health Services website www.health.gov.bc.ca/pcb/rural.html and the BCMA website's member section: www.bcma.org/committee/joint-standing-committee-rural-programs-jsc.

If you have detailed questions, you can contact the Physician Compensation Rural Practice Program at the BC Ministry of Health Services by telephone at 250 952-1104

Update-Year 1, 2 and 3 Micro-Allocation

The micro-allocation fee increases for years 1, 2 and 3 will be implemented on December 19, 2008. Any unprocessed claims or new claims billed at the previous amount will be processed at the new rate for that date of service.

An updated MSC payment schedule will be available by December 19, 2008 at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Retroactive fee increases for paid services provided between April 1, 2006 and December 19, 2008 will be made in the New Year. Due to increased complexity, they will be made in a staged process commencing in February 2009. You will be advised when these payments are made on the broadcast message associated with the remittance statement the payments appear on.

Billing Tips

Bone Densitometry

- Bone Mineral Densitometry fee items (T08688, T08689 and T08696) are not payable unless done using DEXA Technology. Also, when CT-based densitometry (QCT Bone Density) is performed, it is not appropriate to bill these under the CT scan listings.

New Hospital Visit Fees for Community GPs

- Fee items 13228 and 13229 are the only hospital fees billable by community based GP's with courtesy or associate hospital privileges.

Diagnostic Facilities – new fax number

Diagnostic Facilities Administration has a new fax number replacing its former number, 250-952-3133.

Effective November 18, 2008 the new number is:

250 952-2507.

BC Guide for Physicians in Determining Fitness to Drive a Motor Vehicle

New Chapters for Review

The Office of the Superintendent of Motor Vehicles, in partnership with the British Columbia Medical Association (BCMA), has revised the BC Guide for Physicians in Determining Fitness to Drive a Motor Vehicle. The revisions reflect changes to the case law and provide the best evidence available regarding medical conditions and fitness to drive.

Chapters may be viewed on-line at the BCMA Web site via the following link www.bcma.org/driving-fitness-draft-guidelines-osmv and by visiting the Society of General Practitioners of BC Web site by linking to www.sgp.bc.ca/news.php

New and Updated Explanatory Codes

HG Your account has been refused or debited as the patient was out of province on this/these dates.

MJ A fee item has been established for this service. Please resubmit under the approved code.

NM The incentive for full service GP obstetrical bonus is only applicable when fee item 14104, 14108 or 14109 is paid to the same physician/same day.

QN This surgery for alteration of appearance is not a benefit of MSP as the surgery was provided beyond a reasonable period of convalescence.

TK This item is not applicable until the MSP age appropriate counselling fee item (00120 etc) calendar year limit (4) has been utilized New WorkSafe BC Explanatory Code

R1 WorkSafe BC refused – the number of procedural fees exceeds the expedited surgical fee practices.

GUIDELINES & PROTOCOLS

ADVISORY COMMITTEE

Welcome to the GPAC Notice Board!

To make it easier for you to find out what is new and changing with Guidelines and Protocols, we have introduced this new condensed format to easily identify new or updated GPAC information. We will continue to keep you informed of GPAC updates in future editions of the Physicians' Newsletter. As well, you can access the GPAC Notice Board by linking to: http://www.bcguidelines.ca/

Guidelines and Protocols Advisory Committee (GPAC)

The Guidelines and Protocols Advisory Committee (GPAC) is established under the *Medicare Protection Act* as an advisory committee to the Medical Services Commission.

Joint responsibility for the development of clinical practice guidelines is mandated in the 2007 Physician Master Agreement (PMA) between the Ministry of Health Services and the British Columbia Medical Association (BCMA).

The GPAC Notice Board

The Diabetes Care guideline has been updated online at www.BCGuidelines.ca to include a revised Care Objectives table (with revised blood glucose control targets) and separate, printable diagnosis and management algorithms.

The following guidelines were recently approved by the BC Medical Association and the Medical Services Commission, and were posted on the GPAC web site www.BCGuidelines.ca on September 30, 2008:

- Frailty in Older Adults – Early Identification and Management (New Guideline)
- Chronic Kidney Disease – Identification, Evaluation and Management of Patients (Revised Guideline)

New or updated guidelines coming in the fall and winter of 2008/2009 include:

- Acute Chest Pain – Evaluation and Triage (Effective November 10, 2008)
- Stroke and TIA – Prevention and Management (New Guideline)
- Chronic Obstructive Pulmonary Disease
- Anxiety and Depression in Children and Youth (New Guideline)
- Infectious Diarrhea – Guideline for Ordering Stool Specimens
- Dyspepsia With or Without H. pylori Infection
- Gastroesophageal Reflux Disease – Clinical Approach in Adult Patients

Also on September 30, 2008, information on Continuing Medical Education (CME) credits for physicians was posted on the GPAC web site www.BCGuidelines.ca.

Look for the GPAC booth at the Annual Post Graduate Review in Family Medicine Conference, February 4-6, 2009 in Vancouver

Palliative Care

Fee Item 00127 and 13127

This item is applicable to the frequent (usually daily) visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure .

Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.

00127 Hospital visit for terminal care $39.14

Notes:

i) This item is applicable to the frequent (usually daily) visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.

ii) This item should be billed retroactively after death for necessary daily visits rendered for a period not to exceed 90 days prior to death and is applicable to patients in an acute care hospital or nursing home, whether or not the patient is in a palliative care unit.

iii) Terminal care visit fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

iv) The chemotherapy listings (33581, 33582 and 33583) may not be billed when terminal care visit fees are being billed.

13127 Hospital visit for terminal care – First visit of the day $72.01

Notes:

i) Payable only for first in-hospital patient seen on any calendar day.

ii) Not payable in addition to 00127, 00108, 00109, 13008, 13028, 13108, 00128, 13128, P13228, P13229, 12200, 13200, P15200, 16200, 17200, 18200.

iii) This item is applicable to the frequent (usually daily) visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.

iv) Terminal care visit fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

v) The chemotherapy listings (33581, 33582 and 33583) may not be billed when terminal care visit fees are being billed.

Fee items 00127 and 13127 may be billed:

- For frequent (usually daily) visits rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months.
- When care is directed to maintaining the comfort of the patient until death occurs.

Fee items 00127 and 13127 may not be billed:

- When unexpected death occurs after a prolonged hospitalization;
- When admitted for a diagnosis unrelated to the cause of death;
- When aggressive treatment of the disease is taking place (e.g. chemotherapy).

Fee items 00127 and 13127 are billed retroactively after death for a period up to 90 days prior to death, as applicable. Fee items 00127 and 13127 apply to institutional palliative care provided in a hospital, long term care facility or free standing hospice bed. Claims over 90 days old require submission code "A".

Tip: Date of death should be included in the note record.

GPSC MENTAL HEALTH FEE ITEMS

Fee items 14043, 14044, 14045, 14046, 14047, 14048 and 14049 - ICD 9 Codes

The following list of diagnosis and acceptable ICD9 codes are provided to assist you in determining whether the diagnosis meets the criteria for these items. This information will also be posted in the GP services Committee (GPSC) area of the British Columbia Medical Association (BCMA) website.

The GPSC mental health fee items 14043, 14044 - 14048, 14049 are applicable for Axis I diagnosis confirmed by DSM-iv criteria. Effective July 1, 2008 these items will not be accepted unless the diagnosis and ICD9 code submitted with the claim meet these criteria.

	DIAGNOSIS	ICD-9
Adjustment Disorder		309
	Adjustment Disorder with Anxiety	309
	Adjustment Disorder with Depressed Mood	309
	Adjustment Disorder with Disturbance of Conduct	309
	Adjustment Disorder with Mixed Anxiety and Depressed Mood	309
	Adjustment Disorder with Mixed Disturbance of Conduct& Mood	309
	Adjustment Disorder NOS	309
Anxiety Disorders		300
	Acute Stress Disorder	308
	Agoraphobia	300
	Anxiety Disorder Due to a Medical Condition	300
	Anxiety Disorder NOS	300
	Generalized Anxiety disorder	50B, 300
	Obsessive-Compulsive Disorder	300
	Panic Attack	300
	Post-Traumatic Stress Disorder	309
	Social Phobia	300
	Specific Phobia	300
	Substance-Induced Anxiety disorder	300
Attention Deficit Disorders	Attention Deficit Disorder	315
Cognitive Disorders	Amnestic Disorder	294
	Delirium	293
	Dementia	290,331,331.0,331.2
Dissociative Disorders	Depersonalization Disorder	300
	Dissociative Amnesia	300
	Dissociative Fugue	300
	Dissociative Identity Disorder	300
	Dissociative Disorder NOS	300
Eating Disorders	Anorexia Nervosa	307.1, 783.0, 307
	Bulimia	307
	Eating Disorder NOS	307

Factitious Disorders		300,312
	Factitious Disorder; Physical & Psych Symptoms	300,312
	Factitious Disorder; Predom Physical Symptoms	300,312
	Factitious Disorder; Predominantly Psych Symptoms	300,312
Impulse Control Disorders		312
	Impulse Control Disorder NOS	312
	Intermittent Explosive Disorder	312
	Kleptomania	312
	Pathological Gambling	312
	Pyromania	312
	Trichotillomania	312
Mental Disorders Due to a Medical Condition		
Mood Disorders	Bipolar Disorder	296
	Cyclothymic disorder	301.1
	Depression	311
	Dysthymic Disorder	300.4
	Mood Disorder due to a Medical Condition	293.8
	Substance-Induced Mood Disorder	303, 304, 305
Schizophrenia and other Psychotic Disorders		295,296,297,298
	Paranoid Type	295,297,298
	Disorganized Type	295, 298
	Catatonic Type	295, 298
	Undifferentiated Type	295, 298
	Residual Type	295, 298
	Brief Psychotic Disorder	295, 298
	Delusional Disorder	295, 298
	Psychotic Disorder due to Medical Condition	293
	Psychotic Disorder NOS	295, 298
	Schizoaffective Disorder	295, 298
	Schizophreniform Disorder	295, 298
	Substance-Induced Psychosis	295, 298
Sexual and Gender Identity Disorder		302
Paraphilias		302
	Exhibitionism	302
	Fetishism	302
	Frotteurism	302
	Pedophlia	302
	Sexual Masochism	302
	Sexual Sadism	302
	Transvestic Fetishism	302
	Voyeurism	302
	Paraphilia NOS	302

Sexual Dysfunction		302
	Hypoactive Sexual Desire Disorder	302
	Female Orgasmic Disorder	302
	Female Sexual Arousal Disorder	302
	Male Erectile Disorder	302
	Male Orgasmic Disorder	302
	Premature Ejacualation	302
	Sexual Aversion Disorder	302
	Sexual Dysfunction due to a Medical Disorder	625
	Sexual Dysfunction due to a Substance	302
Sexual Pain Disorder	Dyspareunia (not due to a Medical Condition)	302
	Vaginismus (not due to a Medical Condition)	302
Sleep Disorders	Primary Insomnia	307
	Primary Hypersomnia	307
	Narcolepsy	347
	Breathing-Related Sleep Disorder	780.5
	Circadian Rhythm Sleep Disorder	307.4
	Insomnia Related to Another Mental Disorder	307.4
	Nightmare Disorder (Dream Anxiety Disorder)	307.4
	Sleep Disorder Due to a Medical Condition	780.5
	Sleep Disorder Related to another Medical Condition	780.5
	Sleepwalking Disorder	780.5
	Substance-Induced Sleep Disorder	780.5
Somatoform Disorders	Somatization Disorder	300.8
	Conversion Disorder	300.1
	Pain Disorder	307.8
	Hypochondriasis	300.7
	Body Dysmorphic Disorder	300.7
Substance -Related Disorders	Substance-Induced Anxiety Disorder	303, 304, 305
	Substance-Induced Mood Disorder	303, 304, 305
	Substance-Induced Psychosis	292
	Substance-Induced Sleep Disorder	303, 304, 305
Alcohol Dependence Syndrome		303
Drug Dependence Syndrome		304
Drug Abuse, Non-Dependent		305

BRITISH COLUMBIA
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Update to the Medical Services Commission Payment Schedule

Preamble to the Payment Schedule

The following modifications to the Payment Schedule have been approved by the Medical Services Commission:

AMENDMENTS:
Preamble A.17 is modified as indicated in bold:

Specialist/General Practitioner Payment
To be paid by MSP or WCB for specialist consultations, visit items and/or other specialty-restricted fee items listed in the specialty sections of the Payment Schedule, one must be a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty. A specialist recognized in more than one specialty by the College of Physicians and Surgeons of British Columbia should bill consultation and referred items under the specialty most appropriate for the condition being diagnosed and/or treated **for that referral/ treatment period**.

The Preamble to the Payment Schedule – Section B. Terms and Conditions is amended as follows:

B.4. VISITS AND EXAMINATIONS
g. House Call Services

iv) A house call provided for patient convenience should be billed as an out-of-office visit (12200, 13200, P15200, 16200, 17200, or 18200) without a service charge;

Out-of-Office Hours Premiums

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective June 5, 2008.

AMENDMENTS:
Note f) in the Preamble of Out of Office Hours Premiums is amended as indicated in bold:

f) The "home visit" (00103) and "emergency visit when specially called" listings (00111, 00112, 00115, 00205, 02005, 02505, 00305, 00405, 03005, 04005, 00505, 00605, 01705, 06005, 07005, 07805, 08005, 30005, 31005, **32005, 33005, 33205, 33305, 33405, 33505, 33605, 33705,** 77005, 79005, 94005) are not payable in addition to the out-of-office hours premium. Neither are emergency visits payable to the attending surgeon (or his/her substitute) within 10 post-operative days from a surgical procedure (except "operation only" procedures).

Diagnostic and Selected Therapeutic Procedures

NEW FEE ITEMS: **Anes. Level**

The following two new fee item(s) have been approved on a provisional basis, effective February 22, 2008 and will be monitored for a period of 5 years. This Minute will expire on February 28, 2013 or when replaced by a subsequent Minute, whichever occurs first.

P10739 Endobronchial Ultrasound (EBUS) $250.00 6

Notes:

i) Not payable with 00700, 00702, 02450, P10700 or P10702

ii) FI 10703 and 00736 payable in addition

P10703 Transbronchial Needle Aspiration (TBNA) – extra..... 50.00 6

Notes:

i) To a maximum of 3 separate stations or lesions.

ii) Second and third station or lesion payable at 100%

iii) Payable with 00700, 00702 or P10739 and P10700, P10702, 00736

The following two new fee item(s) have been approved on a provisional basis, effective May 30, 2008 and will be monitored for a period of 5 years. This Minute will expire on May 30, 2013 or when replaced by a subsequent Minute, whichever occurs first.

P10700 Endobronchial cautery - extra $75.00 6

Notes:

i) To a maximum of 3 lesions.

ii) Second and third lesion payable at 50%

iii) Payable only with 00700 or 00702 and P10702, P10703, 00736

v) Not payable with P10739 or 02450

P10702 Endobronchial cryotherapy – extra $75.00 6

Notes:

i) To a maximum of 3 lesions.

ii) Second and third lesion payable at 50%

iii) Payable only with 00700 or 00702 and P10700, P10703, 00736

iv) Not paid with P10739, 02450 and 02422

Emergency Medicine

AMENDMENTS:

The Section of Emergency Medicine Preamble is amended as follows:

4) Emergency Medical Consultations

a) A specialist emergency medicine consultation (fee item 01810) only applies to Royal College Certified emergency physicians. Other full-time emergency physicians may bill a general practice out-of-office consultation (fee item 12210, 13210, P15210, 16210, 17210 or 18210) where indicated.

An emergency medicine consultation (whether billed as 01810, 12210, 13210, P15210, 16210, 17210 or 18210) applies only when a patient is referred by another physician (other than an emergency physician at the same institution) who has seen and examined the patient and, because of the complexity, obscurity or seriousness of the problem, the referring physician has requested a consultation.

General Practice

Pursuant to the 2006 Letter of Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

NEW FEE ITEMS:
The following new listings are hereby added, effective as indicated:

G14043 GP Mental Health Planning Fee $100.00

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients resident in the community (home or assisted living, excluding care facilities) with a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- That there has been a detailed review of the patient's chart/history and current therapies;
- The patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- The use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
  - i) PHQ9, Beck Inventory, Ham-D for depression;
  - ii) MMSE for cognitive impairment;
  - iii) MDQ for bipolar illness;
  - iv) GAD-7 for anxiety;
  - v) Suicide Risk Assessment;
  - vi) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
- DSM-IV Axis I confirmatory diagnostic criteria;
- A summary of the condition and a specific plan for that patient's care;
- An outline of expected outcomes;
- Outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists, as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- An appropriate time frame for re-evaluation of the Mental Health Plan;
- That the developed plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other health professionals as indicated.

Notes:

i) Requires documentation of the patient's mental health status and diagnosis by means of psychiatric history, mental state examination, and confirmatory

DSM IV diagnostic criteria. Confirmation of Axis I Diagnosis is required for patients eligible for the GP Mental Health Planning Fee. Not intended for patients with self limiting or transient mental health symptoms (e.g. Brief situational adjustment reaction, normal grief, life transitions) for whom a plan for longer term mental health care is not necessary.

ii) Payable once per calendar year per patient;
iii) Payable in addition to a visit fee billed same day;
iv) Minimum required time 30 minutes in addition to visit time same day;
v) G14016, Community conferencing fee payable on same day for same patient, if all criteria met;
vi) Not payable on the same day as G14044, G14045, G14046, G14047, G14048 (GP Mental Health Management Fees);
vii) Not payable on the same day as G14049 (GP Mental Health Telephone/Email Management fee)
viii) Not intended as a routine annual fee if the patient does not require ongoing Mental Health Plan review and revision;
ix) G14015, Facility Patient Conferencing Fee, not payable on same day for same patient as facility patients are not eligible.

G14044 GP Mental Health Management Fee age 2 – 49.....$50.31
G14045 GP Mental Health Management Fee age 50 – 59.....$55.34
G14046 GP Mental Health Management Fee age 60 – 69.....$57.86
G14047 GP Mental Health Management Fee age 70 – 79.....$62.89
G14048 GP Mental Health Management Fee age 80+.....$65.41

These fees are payable for GP Mental Health Management required beyond the four MSP counselling fees (age-appropriate 00120 fees billable under the MSC payment schedule) for patients with a chronic mental health condition on whom a Mental Health Plan has been created and billed.

Notes:

i) Payable a maximum of 4 times per calendar year per patient;
ii) Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician;
iii) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician;
iv) Not payable unless the age-appropriate 00120 series has been fully utilized;
v) Minimum time required is 20 minutes;
vi) Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14049 (GP Mental Health Telephone/Email Management Fee);
vii) G14016 (Community Patient Conferencing Fee) payable on same day for same patient if all criteria met;
viii) G14015 (Facility Patient Conferencing Fee) not payable on same day as facility patients not eligible;
ix) CDM fees (G14050, G14051, G14052) payable if all criteria met.

G14049 GP Mental Health Telephone/Email Management Fee.....$15.00

This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management by the GP who has created and billed for the GP Mental Health Planning Fee (G14043). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i) Payable to a maximum of five times per calendar year per patient;
ii) Not payable unless the GP/FP is eligible for and has been paid for the GP Mental Health Planning Fee (G14043) during the same calendar year;
iii) Telephone/Email Management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office appointments;
iv) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043) unless that physician has agreed to share care with another

delegated physician;

v) *G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;*

vi) *Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;*

vii) *Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed;*

Eligibility for G14043, G 14044, G14045, G14046, G14047, G14048, G14049

- Eligible patients are community based, living in their home or assisted living. Facility based patients are not eligible.
- Payable only to the GP or practice group that accepts the role of being Most Responsible for the longitudinal, coordinated care of the patient for that calendar year;
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;
- Not payable to physicians who are employed by or who are under contract whose duties would otherwise include provision of this care;
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

The following new fee items for age differential 50 - 59 are added as follows. The notes following each grouping are amended as indicated by adding the applicable new code. The following new fee item(s) have been approved on a provisional basis, effective July 1, 2008 and will be monitored. This Minute will expire on June 30, 2010 or when replaced by a subsequent Minute, whichever occurs first.

P15310 Consultation - in office (Age 50 - 59).....$77.76
P15210 Consultation - out of office (Age 50 – 59).....$93.31
P15301 Complete examination – in office (Age 50 - 59).....$70.69
Note: *Fee items 12101, 00101, P15301, 16101, 17101 and 18101 are subject to the daily volume payment rules described earlier in this section.*
P15201 Complete examination – out of office (Age 50 - 59).....$84.83
P15300 Visit – in office (Age 50 - 59) $31.79
Note*: Fee items 12100, 00100, P15300, 16100, 17100 and 18100 are subject to the daily volume payment rules described earlier in this section.*
P15200 Visit – out of office (Age 50 - 59) $38.15
P15320 Individual counseling – in office (Age 50 - 59) $55.35
Note*: Fee items 12120, 00120, P15320, 16120, 17120 and 18120 are subject to the daily volume payment rules described earlier in this section.*
P15220 Individual counseling – out of office (Age 50 - 59)$66.42

The following new out-of-office fee items are added under the heading for Consultations:

12210 Consultation – out of office (Age 0 – 1).....$93.31
13210 Consultation – out of office (Age 2 - 49).....$84.82
16210 Consultation – out of office (Age 60 - 69).....$97.55
17210 Consultation – out of office (Age 70 - 79).....106.02
18210 Consultation – out of office (Age 80+).....$110.26

The following new fee item has been approved on a provisional basis, effective July 1, 2008. This Minute will expire on June 30, 2010 or when replaced by a subsequent Minute, whichever occurs first.

P14105 Management of labour and transfer to higher level of care facility for delivery $215.17

Notes:

i) *This fee includes all usual hospital care associated with the confinement and provided by the referring physician.*

ii) *May be claimed by the referring physician when the referring physician intended to conduct the delivery providing the following conditions are met:*

a) *The referring physician attended the patient during active labour and provided assessment of the progress of labour, both initial and on-going.*
b) *Active labour is defined as:"regular painful contractions, occurring at least once in five minutes, lasting at least 40 seconds, accompanied by either spontaneous rupture of the membranes, or full cervical effacement and dilatation of at least two centimeters."*
c) *There is a documented complication warranting the referral such as foetal distress or dysfunctional labour (failure to progress).*
d) *Where the referring physician must transfer the patient to another facility.*

iii) Not payable with assessment or visit fee or 14104, 14109 and generally 14199 (provide details if claiming for 14199 in addition).

iv) OOHSC Continuing Care Surcharges do not apply to maternity services in the first stage of labour only.

AMENDMENTS:

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective July 1, 2008.

The following listing is hereby amended by adding the indicated note:

P14105 Management of labour and transfer to higher level of care facility for delivery

Notes:

v) When medically necessary one additional port-partum office visit is payable under FI 14094.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective June 5, 2008.

The descriptions of the following fee items are amended as indicated:

00103 Home visit (call placed between hours of 0800 and 1800 hrs - weekdays.)

00112 Emergency visit (call placed between hours of 0800 and 1800 hrs - weekdays.)

00115 Nursing home visit - one patient, when specially called between hours of 0800 hrs and 1800 hrs – weekdays

Note f) in the Preamble of Out of Office Hours Premiums is amended as indicated in bold:

f) The "home visit" (00103) and "emergency visit when specially called" listings (00111, 00112, **00115,** 00205, 02005, 02505, 00305, 00405, 03005, 04005, 00505, 00605, 01705, 06005, 07005, 07805, 08005, 30005, 31005, 77005, 79005, 94005) are not payable in addition to the out-of-office hours premium. Neither are emergency visits payable to the attending surgeon (or his/her substitute) within 10 post-operative days from a surgical procedure (except "operation only" procedures).

The note in the Section of General Practice, under the major heading for Consultations is amended as follows:

CONSULTATIONS

GP Consultations apply when a medical practitioner (GP or Specialist), or a health care practitioner (midwife, for obstetrical or neonatal related consultations; nurse practitioner; oral/dental surgeon, for diseases of mastication), in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a general practitioner competent to give advice in this field. A consultation must not be claimed unless it was specifically requested by the attending practitioner. The service consists of the initial services of GP consultant, including a history and physical examination, review of x-rays and laboratory findings, necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring practitioner. Consultations will not apply if the referred patient has been attended by the consulting general practitioner or another general practitioner in the same group during the preceding six months.

The descriptions of the following Consultation fee items are amended by changing the descriptions to read "in-office", and to change the age differential under fee item 00110 to read (Age 2-49):

12110 Consultation – **in office** (Age 0 – 1)

00110 Consultation – **in office** (Age 2 – 49)

16110 Consultation – **in office** (Age 60 – 69)
17110 Consultation – **in office** (Age 70 – 79)
18110 Consultation – **in office** (Age 80 +)

In addition, the age-differential descriptions of the following fee items are amended as follows:
00101 Complete examination – in office (**Age 2 - 49**)
13201 Complete examination – out of office (**Age 2 – 49)**
00100 Visit – in office (**Age 2 - 49**)
13200 Visit – out of office (**Age 2 - 49**)
00120 Individual counseling – in office (**Age 2 - 49**)
13220 Individual counseling – out of office (**Age 2 - 49**)

The following notes in the General Practice Preamble are amended by adding the new fee codes as underlined for age differential 50 – 59 under the applicable listing:

NOTE: DAILY VOLUME PAYMENT RULES APPLYING TO DESIGNATED OFFICE CODES

The codes to which these rules apply, and the relative values of these codes (which will be used to determine the application of payment discounts) are as follows:

Office Visits: 12100, 00100, P15300, 16100, 17100, 18100 (1.000)
Office Counseling: 12120, 00120, P15320, 16120, 17120, 18120 (1.741)
Office Complete Examinations: 12101, 00101, P15301, 16101, 17101, 18101 (2.224)

(Relative values are shown in brackets after the code number.)

The following major heading is added to the General Practice Preamble after the second paragraph of section (vii), and the subsequent sentence is amended as follows:

BILLING FOR IN-OFFICE AND OUT-OF-OFFICE VISITS

The following definitions must be adhered to when preparing MSP billings for consultation, complete examination, office visit and individual counseling services (both in and out of office listing).

The following group of codes for IN-OFFICE-FEE ITEMS is amended by adding the underlined codes for: in-office consultations and new codes for age differential 50 - 59.

IN-OFFICE FEE ITEMS: 12110, 00110, P15310, 16110, 17110, 18110, 12100, 00100, P15300, 16100, 17100, 18100, 12101, 00101, P15301, 16101, 17101, 18101, 12120, 00120, P15320, 16120, 17120, and 18120 apply to consultation, visit, complete examination and counseling services provided in offices, clinics, outpatient areas of hospitals,diagnostic treatment centers and similar locations.

The following group of codes for OUT-OFFICE-FEE ITEMS is amended by adding the underlined new codes for: out-of-office consultations and new codes for age differential 50 - 59. In addition, clarifiying wording identifying the locations for which these fee items are applicable is added as indicated in bold:

OUT-OF-OFFICE FEE ITEMS: 12210, 13210, P15210, 16210, 17210, 18210, 12200, 13200, P15200, 16200, 17200, 18200, 12201, 13201, P15201, 16201, 17201, 18201, 12220, 13220, P15220, 16220, 17220, and 18220 apply to **consultation,** visit, complete examination and counseling services provided in either a patient's home, at the scene of an illness or accident, in a hospital in-patient area, **palliative care facility, long term care institution** or in a hospital emergency department, unless the circumstance of the service is specifically covered by the definition of either fee item 00103, 00108, 13008, 00109, 00127, 00128, 13028, 00111, 00112, 00114, 00115, 00113, 00105, 00123, 13108, 13128, 13127, 13114, P13228, P13229 or one of the 01800 series.

The notes under the following fee items are amended by adding the applicable underlined new age 50 – 59 differential fee code(s) as indicated:

Complete Examinations

18101 Complete examination - in office (Age 80+)

***Note**: Items 12101, 00101, P15301, 16101, 17101 and 18101 are subject to the daily volume payment rules described earlier in this section.*

Visits

18100 Visit - in office (Age 80+)

***Note**: Items 12100, 00100, P15300, 16100, 17100 and 18100 are subject to the daily volume payment rules described earlier in this section.*

18200 Visit – out of office (Age 80+)

Note: For fee items 12200, 13200, P15200, 16200, 17200 and 18200, see notes following fee item 00108.

Counseling – Individual

18120 Individual counseling - in office (Age 80+)

***Note:** Items 12120, 00120, P15320, 16120, 17120 and 18120 are subject to the daily volume payment rules described earlier in this section.*

Home Visits

00103 Home visit (call placed between 0800 and 1800 hours)

***Note:** Additional patients seen during same house call are to be billed under the applicable out of office visit fee items (12200, 13200, P15200, 16200, 17200, 18200).*

Hospital Visits

00109 First hospital visit

Notes:

i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a general practitioner. It is not applicable when a patient has been admitted for surgery or for "continuing care" by a certified specialist.

ii) This item is intended to apply in lieu of fee item 00108 on the first in-patient day. However, if extra visits are medically required because of the nature of the problem, 00108 may be billed in addition. An explanation of the reasons for the additional charges should accompany the claim.

iii) Fee item 00109 is not applicable if fee item 12101, 00101, P15301, 16101, 17101, 18101, 12201, 13201, P15201, 16201, 17201 or 18201 has been billed by the same physician within the week preceding the patient's admission.

iv) See the Physician's Resource Manual for additional billing examples

00108 Visit

Notes:

i) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108. The claim must include the time of each visit and a statement of need included in a note record. For daytime emergency visit, see fee item 00112.

ii) Fee items 12200, 13200, P15200, 16200, 17200 or 18200 may be billed for additional hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in a note record.

iii) Call-out charges may be billed in conjunction with 12200, 13200, P15200, 16200, 17200 or 18200 if all the out-of-office hours premium criteria are met.

13108 Hospital Visit - first routine visit of the day

Notes:

i) Payable only for first in-hospital patient seen on any calendar day.

ii) Not payable in addition to 00108,13008, 00109, 00112, 00128, 13127, 13028, 13128, P13228, P13229, 12200, 13200, P15200, 16200, 17200, 18200, except as set out in notes iii) and iv).

iii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record. For daytime emergency visit, see fee item 00112.

iv) Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in the note record.

v) Hospital visits on other than the first visit of the day remain payable under the appropriate listing (e.g., 00108, 13008 or 00109).

13128 Supportive care - first in-hospital visit of the day

Notes:

i) Payable only for first in-hospital patient seen on any calendar day.

ii) Not payable in addition to 00108, 13008, 00112, 00128, 13108, P13228, P13229, 13127, 12200, 13200, P15200, 16200, 17200, 18200 except as set out in the following notes iii) and iv).

iii) Essential non-emergent additional visits to a hospitalized patient by the physician providing supportive care for diagnoses unrelated to the referral, during one day are to be billed under fee item 00108. The claim must include the time of each visit and a statement of need included in a note record. For daytime emergency visit, see fee item 00112.

iv) Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in the note record.

v) Supportive care visits on other than the first visit of the day remain payable under 00128.

vi) Only one visit under 13108, 13127 or 13128 billable by same physician, same day.

vii) Preamble B.4.e.v) regarding supportive care is also applicable.

P13228 Full Service Family Medicine (hospital) visit

Notes:

i) Payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record

ii) Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

iii) Payable to practitioners currently in general practice in BC as a full service family physician who are responsible for providing the patient's longitudinal general practice care.

iv) Payable for patients in acute, sub-acute care or palliative care.

v) Not payable with 14015 or any other visit fee including P13229, 00108, 13008, 13108, 00109, 13114, 16200, 17200, 18200, 12201, 13201, P15201, 16201, 17201, 18201, T12148, T13148, 00128, 13028, 13128, 13015, 12220, 13220, P15220,16220, 17220, 18220, 00121, 00122, 12210, 13210, P15210, 16210, 17210, 18210, 00116, 00112, 00111.

vi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the patient as a requirement of their employment or contract with the facility or physicians working under salary, service contract or sessional arrangements.

vii) A written record of the visit must appear in either patient's hospital or office chart.

viii) This fee is intended for physicians with courtesy or associate hospital privileges.

ix) If a hospitalist is providing GP care to the patient, the full service family physician may bill P13228 or P13229 (if first visit of day).

P13229 Full Service Family Medicine (hospital) visit – 1st visit of the day

Notes:

i) Payable only for first in-hospital patient seen on any calendar day.

ii) Payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.

iii) Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

iv) Payable to practitioners currently in general practice in BC as a full service family physician who are responsible for providing the patient's longitudinal general practice care.

v) Payable for patients in acute, sub-acute care or palliative care.

vi) Not payable with 14015 or any other visit fee including P13228, 00108, 13008, 13108, 00109, 13114, 00114, 00115, 00113, 00105, 00123, 00127, 13127, 12200, 13200, P15200, 16200, 17200, 18200, 12201, 13201, P15201, 16201, 17201, 18201, T12148, T13148, 00128, 13028, 13128, 13015, 12220, 13220, P15220, 16220, 17220, 18220, 00121, 00122, 12210, 13210, P15210, 16210, 17210, 18210, 00116, 00112, 00111.

vii) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the patient as a requirement of their employment or contract with the facility or physicians working under salary, service contract or sessional arrangements.

viii) A written record of the visit must appear in either patient's hospital or office charts.

ix) This fee is intended for physicians with courtesy or associate hospital privileges.

x) If a hospitalist is providing GP care to the patient, the full service family physician may bill P13228 or P13229 (if first visit of day).

T13148 Sub-acute hospital visit – 1st visit of the day

Notes:

i) Payable only for first patient seen in a sub-acute facility on any calendar day

ii) Not payable on the same day to the same physician as 13108, 13114, 13127 or 13128 unless provided in a discrete facility which is in a separate geographic location from the acute care or extended care facility.

iii) *Not payable on the same day to the same physician for the same patient in addition to 00108, 13008, 00109, 00112, 00128, 13028, 13108, 13127, 13128, 12200, 13200, P15200, 16200, 17200, 18200 and 13114 except as set out in notes iv) and v).*

iv) Essential non-emergent additional visits to a patient in a sub- acute facility by the attending or replacement physician during one day are to be payable under fee item T12148. The claim must include the time of each visit and a statement of need included in a note record. For daytime emergency visit, see fee item 00112.

v) Fee items 12200, 13200, P15200, 16200, 17200, 18200 are payable for additional sub-acute hospital visits same day, same patient when the attending physician or replacement physician is specially called back due to a change in the patient's condition which requires the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in the note record.

vi) Sub-acute hospital visits on other than the first visit of the day remain payable under T12148.

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective April 1, 2008:

Note i) of the following fee item is modified by adding the underlined information as follows:

13008 Community GP Hospital Visit.....39.14

This item is payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for longitudinal, coordinated care of that patient.

Notes:

i) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included a note record. For daytime emergency visit, see fee item 00112.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 1, 2008.

The payment rate of the following fee item is amended as follows:

T12148 Sub-acute hospital visit $39.14

***Note** i) appended to fee item 00127 is amended as follows in bold and the payment rate is adjusted as indicated:*

00127 Hospital visit for terminal care..... $39.14

Notes:

i) This item is applicable to the frequent (usually daily) visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS ***or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure.*** *Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.*

Notes ii) and iii) appended to fee item 13127 are amended as follows in bold:

13127 Hospital visit for terminal care – First visit of the day

Notes:

ii) Not payable in addition to 00127, 00108, 00109, ***13008, 13028,*** *13108,* ***00128,*** *13128,* ***P13228, P13229,*** *12200, 13200,* ***P15200,*** *16200, 17200, 18200.*

iii) This item is applicable to the frequent (usually daily) visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS ***or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure.*** *Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.*

The notes following fee item 14094 are amended as follows:

14094 Post-natal office visit

Notes:

i) 14094 may be billed once only in the six weeks following delivery (vaginal or Caesarean Section)

ii) Not payable to physician performing Caesarean Section

The following fee items are amended by adding the bolded note:

14104 Delivery and post-natal care

Notes:

i)Care of newborn in hospital (see item 00119).

ii)Repair of cervix is not included in fee item14104. Charge 50% of listed fee when done on same day as delivery.

*iii)**When medically necessary one additional post-partum office visit is payable under FI 14094.***

14108 Post-natal care after elective cesarean section

Note: When medically necessary one additional post-partum office visit is payable under FI 14094.

14109 Attendance at delivery and post-natal care associated with emergency cesarean section

***Notes**:*

i) Surgical assistant is extra to fee items 14108 and 14109.

ii) ***When medically necessary one additional post-partum office visit is payable under FI 14094.***

Ophthalmology

AMENDMENTS:

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective October 16, 2008:

The following fee item description is hereby modified as indicated:

02010 **Consultation:** To include history, eye examination, review of X-rays and laboratory findings and in addition where indicated and necessary, any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test and keratometry, in order to prepare and render a written report.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 1, 2008:

The cancellation dates of the following provisional items have been extended. This Minute will expire on June 30, 2009 or when replaced by a subsequent Minute, whichever occurs first.

P22067 Computerized retinal nerve fibre layer photography and neuro-retinal assessment (e.g.: Heidelberg, GDX).....$63.92

P22068 - professional fee.....$12.28

P22069 - technical fee.....$51.64

Notes:

i) Requires both qualitative and quantitative assessments.

ii) Includes examination of both eyes whether at one time or two separate visits.

iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

Cardiology

NEW FEE ITEMS:

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective April 1, 2008.

The following new listing is hereby added under the heading "Electrophysiological Mapping and Ablation":

33084 Catheter ablation for atrial fibrillation.....$1500.00 6

Note:

Includes percutaneous right heart catheterization, transseptal left heart catheterization, all diagnostic imaging, ECG's (electrophysiological mapping/ablation fee items 33066, 33085, 33086, and 33087).

AMENDMENTS:

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective October 20, 2008:

The "S" (designates fee items for which a surgical assistant's fee is not payable) prefix is hereby deleted from the following fee items:

Cardiology Assist Fees:

00845 For first hour or fraction thereof

00846 After one hour, for each 15 minutes or fraction thereof

Gastroenterology

AMENDMENTS:

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective November 1, 2008:

The cancellation date of the following provisional item has been extended. This Minute will expire April 30, 2010 or when replaced by a subsequent Minute, whichever occurs first:

P10708 Video Capsule endoscopy using M2A capsule – professional fee.....$250.00

Notes:

i) Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have ruled out other causes.

ii) Limited to services rendered at St. Paul's Hospital, Vancouver only.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 14, 2008:

Note ii) following fee item P10742 is revised as indicated as follows in bold:

P10742 Upper GI endoscopy utilizing radial/ linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 – per lesion..... $50.00

Notes:

i) Payable with P10740 or P10741 only.

ii) ***First biopsy paid at 100%. Second and third*** *biopsies payable at 50%.*

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 24, 2008:

The provisional status (P prefix) of the following fee items is hereby rescinded:

10735 Rectal endoscopy utilizing ultrasound (radial/linear)

10740 **Error! Bookmark not defined.**Upper GI endoscopy utilizing radial ultrasound

10741 Upper GI endoscopy utilizing linear ultrasound

10742**Error! Bookmark not defined.** Upper GI endoscopy utilizing radial/ linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 - per lesion

10743 Upper GI endoscopy utilizing radial/linear ultrasound - with injection of one of more of any of the following – metastases, nodes, masses, or celiac plexus - extra

10744 Upper GI endoscopy utilizing radial/linear ultrasound - with drainage of pseudocyst (including stent insertion if performed) - extra

Respirology

DELETED FEE ITEM:

The following fee item is hereby deleted, effective October 31, 2008.

S00331 Closed drainage of chest – operation only.....$105.08 4

NEW FEE ITEMS:

The following new fee item is hereby added, effective November 1, 2008.

S32031 Closed drainage of chest – operation only.....$105.08 4

The following new fee items have been approved on a provisional basis, effective November 16, 2007. These fee items will be monitored for a period of one year, effective September 1, 2008 to August 31, 2009. This Minute will expire on November 30, 2009 or when replaced by a subsequent Minute, whichever occurs first.

P10320 Insertion of permanent pleural drainage catheter.....$200.00 5

Notes:

i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter

ii) Not paid with 00331, 00749, 00759, 07924 and 08646

P10321 Removal permanent pleural drainage catheter $67.39 2
***Note**: Not paid with 00331, 00749, 00759, 07924 and 08646*

The following two new fee item(s) have been approved on a provisional basis, effective May 30, 2008 and will be monitored for a period of 5 years. This Minute will expire on May 30, 2013 or when replaced by a subsequent Minute, whichever occurs first.

P10700 Endobronchial cautery - extra $75.00 6
***Notes**:*
i) To a maximum of 3 lesions.
ii) Second and third lesion payable at 50%
iv) Payable only with 00700 or 00702 and P10702, P10703, 00736
v) Not payable with P10739 or 02450

P10702 Endobronchial cryotherapy – extra $75.00 6
***Notes**:*
i) To a maximum of 3 lesions.
ii) Second and third lesion payable at 50%
iv) Payable only with 00700 or 00702 and P10700, P10703, 00736
iv) Not paid with P10739, 02450 and 02422

The following two new fee item(s) have been approved on a provisional basis, effective February 22, 2008 and will be monitored for a period of 5 years.

P10739 Endobronchial Ultrasound (EBUS) $250.00 6
Notes:
i) Not payable with 00700, 00702, 02450, P10700 or P10702
ii) FI 10703 and 00736 payable in addition

P10703 Transbronchial Needle Aspiration (TBNA) – extra $50.00 6
***Notes**:*
i) To a maximum of 3 separate stations or lesions.
ii) Second and third station or lesion payable at 100%
iii) Payable with 00700, 00702 or P10739 and P10700, P10702, 00736

General Surgery

NEW FEE ITEMS:

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective April 1, 2008. The following new fee item(s) have been approved on a provisional basis, effective as indicated. This Minute will expire on September 30, 2009 or when replaced by a subsequent Minute, whichever occurs first.

P71623 Laparoscopic initial ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis. $550.00 5
Note: Lysis of adhesions not payable in addition.

P71624 Laparoscopic recurrent ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis. $700.00 6
Note: Lysis of adhesions not payable in addition.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 1, 2008. The following new fee item(s) have been approved on a provisional basis, effective as indicated and will be monitored for a period of 18 months to ensure adequate funding is available from the following deleted listing. This Minute will expire on December 31, 2009 or when replaced by a subsequent Minute, whichever occurs first.

P70650 Lysis of intra-abdominal adhesions – first 30 minutes (extra) $150.00 7

P70651 - each additional 15 minutes or greater portion thereof (extra) $75.00

Notes:

i) Restricted to General Surgeons only.
ii) Payable for open procedures only
iii) Not payable with fee item 07650.
iv) Not payable to same general surgeon doing the surgical assist.
v) Start and stop times for Lysis must be provided in patient chart and claim time field.

AMENDMENTS:

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective June 28, 2008.
The following note subsequent to fee item 70645 is rescinded:

70645 Revision or reversal of gastric restrictive procedure for morbid obesity .....
with takedown gastroenterostomy and reconstituin of small bowel integrity
.....$771.53 7

DELETIONS:

The following heading, fee item and accompanying notes are hereby deleted from the Section of General Surgery Payment Schedule, effective June 30, 2008.

Repeat Surgery

07043 Repeat surgery may be charged at 125% of the listed fee for the repeat surgery performed. State original procedure and its fee code.

Notes:

i) Repeat surgery means surgery performed more than 21 days after original surgery on the same organ.
ii) For the abdomen, "organ" means stomach, duodenum, jejunum, ileum, ascending colon, transverse colon, left colon, and biliary tract. For other abdominal cases where massive adhesions are present, 07043 may apply upon submission of operative report.
iii) Fee Item 07043 is not applicable to operations on the skin or subcutaneous tissues, or to other than general surgery listings.
iv) For repeat surgery performed within 21 days, 100% of the listed fee applies (except when the note regarding repeat vascular surgery within 24 hours applies).
v) For re-dissection of groin with revision of graft, item 07043 does not apply - see vascular surgery fee item 77112, instead.

Vascular Surgery

NEW FEE ITEMS:

The following item(s) are effective on a temporary basis from January 25, 2008 until July 31, 2010. On July 31, 2010 and after review by the British Columbia Medical Association, a recommendation may be made to remove the temporary status:

Operative repair – arteriography – for Iatrogenic injury during percutaneous endovascular aortic valve implantation

T77352	Repair of major vessel in extremity - suture	523.42	
T77353	Repair of major vessel in extremity - graft	673.27	
T77354	Repair of major vessel in trunk - surture	785.66	
T77355	Repair of major vessel in trunk - graft	1,047.91	

Cardiac Surgery

AMENDMENTS:

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective November 1, 2008. The cancellation date of the following provisional item has been extended. This Minute will expire April 30, 2010 or when replaced by a subsequent Minute, whichever occurs first.

P78041 Laser Lead Extraction after 30 days, first lead $1331.92 9

Notes:

i) Not payable with 07845, 00330, and 00357.
ii) Includes any and all diagnostic imaging related to the surgery.
iii) Claims for surgical assistance for laser lead extraction are payable under 0197.

P78042 Laser Lead Extracton after 30 days, additional leads, to a maximum of two – extra $500.00 9

P78043 Debridement of chest wall during laser lead extraction – extra (payable only with 78041) $50.00 9

P78044 Wide debridement of chest wall during laser lead extraction - extra (payable only with 78041) $100.00 9

The following modification to the Payment Schedule has been approved by the Medical Services Commission, effective October 21, 2008.

The following listing is hereby amended by modifying the indicated note:

P78041 Laser Lead Extraction after 30 days, first lead $1331.92 9

Notes:

i) Not payable with 07845, 33030, and 33057.

Diagnostic Radiology

NEW FEE ITEMS:

The following new fee item(s) have been approved on a provisional basis, effective July 1, 2008. This Minute will expire on December 31, 2009 or when replaced by a subsequent Minute, whichever occurs first.

P10913 Cerebral arterial balloon occlusion tolerance test $753.37 5

Note:

i) Payable for procedures performed on cerebral, carotid or vertebral arteries;
ii) Radiological assists payable under fee items 08632 and 08633.
iii) Includes all neurological exams done in association with the procedure, anydiagnostic angiography done immediately prior to or during the procedureand any necessary imaging performed at the time of the procedure;
iv) Payable once per day, regardless of the number of balloon catheters inserted;
v) Repeats within 30 days included in payment for original procedure.
vi) Consultations payable in addition;

vii) *Included in payment for endovascular obliteration of an aneurysm using the GDC technique (FI 10915), or embolization (fee items : T00995, T00997,T00998) if performed on the same day.*

P10914 Percutaneous balloon angioplasty for cerebral vasospasm $968.30 9

Notes:

i) *Includes all neurological exams done in association with the procedure,diagnostic cerebral angiography done during the procedure and any necessary imaging performed at the time of the procedure;*
ii) *Includes catheterization of any and all cerebral arteries.*
iii) *Payable once per day regardless of number of vascular territories or times treated.*
iv) *Medically necessary extra cranial angioplasty and stenting required to enable access for balloon angioplasty payable at 50% of 00982*
v) *Consultation payable only if procedure is cancelled subsequent to consultation.*
vi) *Radiological assists are payable under fee items 08632 and 08633.*
vii) *Physician may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted P10914. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100 percent for the first angiogram and 50 percent for subsequent angiograms, to a maximum of 75% of fee item P10914. Claims must be accompanied bywritten details of vessels injected.*
viii) *Not payable with fee item 10905 (Cerebral intra-arterial thrombolysis).*

P10915 Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique $1,883.43 7

Notes:

i) *Includes all neurological exams done in association with the procedure, any diagnostic angiography performed at time of procedure and any necessary imaging performed at the time of the procedure;*
ii) *Includes P10913 when performed on same day;*
iii) *Separate micro catheterization included if required;*
iv) *Consultation payable only if procedure is cancelled subsequent to the consultation;*
v) *Multiple aneurysms paid as follows: 2nd – 50 percent; 3rd – 25 percent (to a maximum of three aneurysms);*
vi) *Radiological assists are payable under fee items 08632 and 08633;*
vii) *Fee item 08629 not payable in addition.*
viii) *Physician may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted P10915. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100 percent for the first angiogram and 50 percent for subsequent angiograms, to a maximum of 75% of fee item P10915. Claims must be accompanied by written details of vessels injected.*

P10918 Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance $443.16 6

Notes:

i) *Payable once per day, regardless of the number of lesions treated on head or neck;*
ii) *Fee item 08629 not payable in addition;*
iii) *Consultation payable only if procedure is cancelled subsequent to the consultation;*
iv) *Includes necessary post-operative visits by physician performing procedure;*
v) *Compression sclerotherapy listings (fee items 77050 – 77060) not payable with P10918.*

P10916 Complex diagnostic neuroangiography for the assessment of complex vascular tumors or vascular malformations – up to 4 hours procedural time $1,107.90 5

P10917 - after 4 hours (extra to P10916) $276.98

Notes:

i) Includes injection of six or more intracranial or extracranial vessels in the head, neck and/or spine, or if procedure requires use of microcatheters, injection of four or more vessels.

ii) Start and stop times must be noted in claim submission

iii) This listing is not payable when performed concurrently with other interventional radiology procedures.

iv) Subsequent consecutive interventional radiology procedures are payable at a) 50% if performed by same operator; b) 100% if performed by different operator.

The following fee items have been approved on a provisional basis. The new fee items contained in this Minute will expire on December 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P10919 Intravascular stent placement – extra $120.00

Notes:

i) Includes all diagnostic imaging associated with stent placement.

ii) Payable once only when contiguous vessels are stented and/or where more than one stent is used per site.

iii) Placement of second stent in non-contiguous site payable at 50%.

iv) Procedures repeated within 30 days are payable at 50%.

v) Consultation payable only if procedure is cancelled subsequent to consultation.

vi) Applicable to radiologist-inserted stents only.

vii) Not payable for Coronary stent placement.

P10920 Intracorporeal stent placement – extra $120.00

Notes:

i) Includes all Diagnostic imaging associated with stent placement.

ii) Includes all associated tract dilation(s).

iii) Second procedure same day payable at 50%.

iv) Removal of stent within 6 months of insertion payable at 50%.

v) Consultation payable only if procedure is cancelled subsequent to the consultation.

vi) Payable only when stents are placed in the same organ and/or where more than one stent is used per site or when repositioning of stent required.

vii) Placement of second stent in non-contiguous site payable at 50%.

viii) Applicable to radiologist-inserted stents only.

The following new fee item has been approved on a provisional basis, and will be added to the Chemistry Section of the Laboratory Medicine Fee Schedule, effective January 25, 2008. This Minute will expire on July 31, 2009 or when replaced by a subsequent Minute, whichever occurs first:

P91761 Heliobacyter Pylori stool antigen (HPSA) $33.95

The following new fee item has been approved on a provisional basis, effective April 29, 2008. This Minute will expire December 31, 2008 or when replaced by a subsequent Minute, whichever occurs first.

P90784 Trichomonas Antigen Test $11.09

***Note**: Not payable with 90785*

The following new fee items have been approved on a provisional basis, effective April 25, 2008. This Minute will expire on March 31, 2010 or when replaced by a subsequent Minute, whichever occurs first.

P90653 Gonorrhea by NAAT – urine $4.65

***Note**: Payable only when performed with 90651*

P90654 Gonorrhea by NAAT – urogenital swab $4.65

***Note**: Payable only when performed with 90652*

AMENDMENTS:

1. Effective July 1, 2008, Note vi) subsequent to fee item 83000 (Interventional Radiology Consultation) is hereby amended by adding the following:
   e) Cerebral arterial balloon occlusion tolerance test (P109013)

2. Effective July 1, 2008, Note vii) subsequent to fee item 83000 (Interventional Radiology Consultation) is hereby amended by adding the following:
   r) Percutaneous balloon angioplasty for cerebral vasospasm (P10914)
   s) Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique (P10915)
   t) Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance (P10918)

3. Effective July 1, 2008, Note i) following fee item 08633 (Radiology Assistant Fee) is hereby modified as follows:
   Note: *08632 and 08633 may be applicable:*
   i) when a radiology assistant is required in conjunction with 00738, 00979, 00980, 00981, 00982, 00996, 00997, 00998, P10913, P10914 and P10915;

4. Effective July 1, 2008, the following note is hereby added to the Notes subsequent to fee item 00998 and pertaining to 00995, 00997 and 00998
   v) Includes P10913 if performed on same day as 00995, 00997 or 00998.

Effective November 16, 2007, note vii) subsequent to fee item 83000 (Interventional Radiology Consultation) is hereby amended by adding the following:

p) Intravascular stent placement (P10919)
q) Intracorporeal stent placement (P10920)

Laboratory Medicine

NEW FEE ITEM:

The following new fee item has been approved on a provisional basis, effective September 1, 2008. This Minute will expire on March 31, 2009 or when replaced by a subsequent Minute, whichever occurs first.

P91925 Light Chains, free kappa and lambda with ratio - quantitative $32.74

Note: *Payable for Plasma cell dyscrasias including oligo-secretory or non-secreting myeloma, primary amyloidosis, light-chain only form of myeloma and monoclonal gammopathy of unknown significance.*

AMENDMENTS:

The payment rate for fee item P91275 is amended prospectively and retrospectively from $34.50 to the indicated rate, effective November 1, 2007. In addition, the notes are amended as indicated in bold:

P91275*** B-type natriuretic peptide (BNP or NT-pro BNP).....$47.25

Notes:

Payable for:

i) assessment of symptomatic patients where the diagnosis of heart failure remains in doubt after standard assessment.
ii) repeat testing not payable more than once annually unless ordered by the physician for new clinical episode suspicious for heart failure **or in the tertiary cardiac care outpatient setting for prognostic stratification of heart failure**
iii) not payable for repeat testing for monitoring therapy

Effective May 14, 2008, fee item P91760 is hereby amended by removing the triple-asterisk designation and modifying the prefix from "P" to "T" as follows:

T91760 Heliobacter Pylori Carbon 13 urea breath test

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective September 1, 2008.
The asterisk designation is hereby removed from the following fee item and the indicated note is added:

91170 Apolipoprotein B-100

Note: *Not payable with 91375, 91780, or 92350 (Lipid profile, or partial profile) unless specifically requested and the triglycerides are greater than 4.5 mmol/L.*

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective July 8, 2008.
The indicated notes are added to the following fee item:

91340 Carbon monoxide, quantitative

Notes:

i) Payable for carboxyhemoglobin determinations utilizing a blood gas analyzer.
ii) Not payable with 92045.

The following note is added to the indicated fee item as follows, effective August 25, 2008:

T92545 GC/MS Confirmation of Positive Screen

***Notes**: Payable for confirmatory methods utilizing liquid chromatography mass spectrometry (LC-MS).*

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Reminding all healthcare workers:

Hope Air is here to help your patients

Hope Air is unique!

Hope Air is the only national charity in Canada that arranges free air transportation to medical appointments for people in financial need. For over 22 years, Hope Air has arranged Flights for Canadians of all ages and illness groups. During the past 2 years, Hope Air has arranged more flights for residents of British Columbia than any other province in Canada.

How can Hope Air help your patients?

Hope Air may be able to provide a free flight for your patient (including their escort if patient is under 18 years-of-age) from their home community to the city of their medical appointment.

Hope Air is not an air ambulance. Rather, it provides flights on both commercial airlines and on private planes from rural/remote locations to "the big city" and also from major city to major city. The following will be considered by Hope Air when reviewing a flight request:

- flying for an approved medical appointment (e.g. provincial health plan covered); and
- patient is in financial need

How quickly can Hope Air respond to my patient's need?

Very quickly! Hope Air wants to help as many people as possible so we do everything we can to get patients to their appointments. Advance notice ensures that we are able to get in touch with the patient's doctors to confirm appointment and medical clearance to fly in a timely manner, but we recognize that sometimes appointments get scheduled at the last minute. Just have the patient call us and we will do everything we can to help.

What should I do with this information?

1. Spread the word – let people know that Hope Air is a resource they can depend on
2. Share this article with your office staff – especially your medical office assistant and the individual who does your referral calls for out-of-town appointments
3. Refer patients to the Hope Air website or phone number below
4. Call Hope Air and ask for brochures and a bulletin board poster for your office waiting area

1 877 346-4673
www.hopeair.org

Expanded Role for B.C. Pharmacists

In September 2006, the provincial government launched the Conversation on Health, the most wide-ranging public discussion on the public health care system ever held in British Columbia. British Columbians were asked how government might strengthen the health system within the *Canada Health Act* and secure it for future generations.

Pharmacists can now use the full extent of their knowledge, skills and abilities to the benefit of their patients and the health care system.

Some ideas arising from the Conversation on Health were reflected in the February 2008 Throne Speech. Among these was the announcement that, "Pharmacists will be permitted to authorize routine prescription renewals, making it easier for patients with chronic illnesses to manage their conditions." The Throne Speech described this and other legislative changes as being designed to support the values of individual choice and expanded access to qualified health professionals and primary care.

Following commitments made in the Throne Speech, Health Minister George Abbott introduced the *Health Professions Regulatory Reform Act* in April 2008, which, among other amendments, formalizes a pharmacist's authority to renew prescriptions.

In September 2007, the Council of the College of Pharmacists of B.C. (CPBC) approved Professional Practice Policy #58 (PPP-58), *Protocol for Medication Management (Adapting a Prescription)*. This policy provides the framework, expressed as seven fundamentals, to guide pharmacists in the safe and effective renewal of prescriptions as well as the adaptation of existing prescriptions already provided for by the legislation. With this in place, pharmacists can maximize their educational and professional competencies and more fully complement the role of the physician as the primary prescriber by delivering effective drug therapy and facilitating continuity of care.

It is important to note that **only existing, valid prescriptions can be renewed or adapted** and:

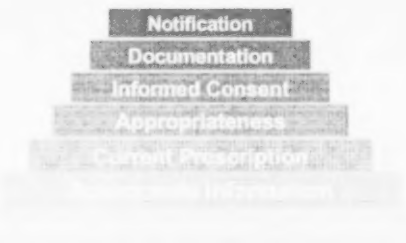
- Pharmacists are authorized, *but not obligated*, to renew or adapt prescriptions.
- Pharmacists cannot renew or adapt prescriptions for narcotics, controlled drugs or targeted substances.
- Pharmacists must assume liability for a renewed or adapted prescription and must hold liability insurance (minimum $2 million). The pharmacist's name is also recorded on the PharmaNet transaction.
- In renewing or adapting prescriptions, pharmacists must follow the Seven Fundamentals outlined in the CPBC's PPP-58 (see page two of this document).
- Renewals can be made only for stable, chronic conditions (i.e., if the patient has been on the same medication, without change, for at least six months) and pharmacists can renew a prescription for up to six months from the date of the original prescription. Psychiatric medication renewals are reserved for pharmacists working in multi-disciplinary teams.
- Outside practice settings such as hospitals, residential care facilities or multi-disciplinary environments in which collaborative relationships or appropriate protocols are established:
  - pharmacist therapeutic substitution of a prescription will be limited to Histamine-2 receptor (H2) blockers, non-steroidal anti-inflammatory drugs (NSAIDS), nitrates, angiotensin converting enzyme (ACE) inhibitors, dihydropyridine calcium channel blockers (CCBs) and proton pump inhibitors (PPIs), similar to government policy; and
  - pharmacists will not change the dose or regimen of prescriptions for patients with cancer, cardiovascular disease, asthma, seizures or psychiatric conditions, however, pharmacists can complete missing information if there is historical evidence to support it.

- Pharmacists will honour handwritten "Do Not Renew/Adapt" instructions on prescriptions. If a physician produces their prescriptions electronically, they must sign or initial beside the "Do Not Renew/Adapt" notation.
- The CPBC has established the *Monitoring Adapting Prescriptions Task Force*, with members from the BC Pharmacy Association (BCPhA), the BCMA, the CPSBC and the Ministry of Health Services, to carefully monitor this new authority, review the limits and conditions and make recommendations.

Throughout the fall, the CPBC and the BCPhA have been hosting provincewide orientation sessions and distributing educational materials to prepare pharmacists for the change.

The Ministry of Health Services is now working with the CPBC and the BCPhA to inform British Columbians of the changes coming on January 1, 2009. Information for patients will emphasize the importance of establishing an ongoing relationship with their pharmacist, the need for their pharmacist to be guided by their professional judgment when deciding if it is appropriate to renew or adapt a prescription, and the continued need for patients to see their physicians for evaluation, diagnosis, treatment initialization or cessation, and follow-up.

Seven Fundamentals of Renewing/Adapting a Prescription



As described in PPP-58, pharmacists may renew or adapt a prescription only if the action is aimed at optimizing the therapeutic outcome and the pharmacist addresses the following fundamentals in sequential order:

1. **Pharmacist's individual competence**—The pharmacist must have appropriate knowledge and understanding of the patient's unique health situation.
2. **Appropriate information**—The pharmacist must have sufficient information about the patient's health status to be satisfied that any prescription change will maintain or enhance the effectiveness of the drug therapy without putting the patient at increased risk.
3. **Current prescription**—The patient's prescription must be current and authentic. A pharmacist cannot renew or adapt a prescription if the original prescription has expired.
4. **Appropriateness of adaptation**—A pharmacist must make ethical decisions in the best interest of the health of the patient.
5. **Informed consent**— In British Columbia, the *Health Care (Consent) and Care Facility (Admission) Act* sets out the criteria and process for obtaining valid consent from a patient. A pharmacist must obtain patient consent to any proposed treatment and the patient must give that consent voluntarily and be a capable adult.
6. **Documentation of rationale**—A pharmacist must document all prescription changes to create an accurate record of the circumstances and details of the change.
7. **Notification of prescriber**—Whenever a pharmacist renews or adapts a prescription in any way, the pharmacist must notify the original prescriber and/or most responsible clinician as soon as possible, preferably within 24 hours.

In implementing each of the seven fundamentals, pharmacists must ensure their decision is justifiable and would stand the test of reasonableness.

For more information on prescription renewal and adaptation by pharmacists, visit the Key Initiatives section of the CPBC website at www.bcpharmacists.org.